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Standards in visiting nurse
work

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Standards in Visiting Nurse Work

BY

LEE K. FRANKEL

Sixth Vice-President
Metropolitan Life Insurance Company

Read at a Meeting of the
NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING,
San Francisco, Cal., June 22, 1915

541 316 288 72

Standards in Visiting Nurse Work

Ladies:

The day has gone by when it is necessary to offer apologies for visiting nursing. This form of activity is to-day well recognized as an important factor in the improvement of health conditions. Beginning as a philanthropy primarily for bringing medical service into the homes of the poor, visiting nursing has evolved by leaps and bounds. To-day the visiting nurse is used not only as a philanthropic measure, but by health officers in the health work of their respective communities, by private organizations engaged in the prevention of disease, by industrial establishments to enable them to care properly for their employees and by insurance companies to promote the physical welfare of their policy-holders.

With the development of visiting nurse work, there have come certain responsibilities. Not the least of these is the necessity for a careful accounting of the work done. The health officer must know the results which he has obtained through the service of the visiting nurse so that he may make an intelligent presentation of the subject in his attempt to secure municipal or state funds. The private society or organization, which utilizes the nurse, to-day, like any other philanthropic organization, is held to an accounting to its contributors, and, finally, the insurance company, responsible to the public and to its constituency, must know in appropriating policy-holders' funds in work of this kind whether the results obtained are commensurate with the outlay involved and whether insurance commissioners, who periodically examine the accounts of insurance companies, will give the stamp of approval to the expenditure of policy-holders' savings along lines which apparently do not come directly within the purview of insurance.

The purpose of this paper is to present to you certain facts regarding visiting nurse work which have come within our experience, as a result of the service we are giving to policy-holders in the United States and Canada. It has been our effort from the beginning to compile records from which it might be possible to determine whether the results obtained

justified a continuation of this work. The statistics which we obtained in the earlier years, particularly in the years 1911 and 1912 were somewhat unsatisfactory by reason of the fact that nursing associations and visiting nurses generally had not yet learned the necessity of carefully recording both the medical and social facts of the cases which they nursed. It is for this reason that we have insistently dwelt upon the necessity of having a uniform system of records, and that the important facts on these records, such as diagnosis, condition on discharge, etc., should be carefully noted. It is gratifying to be able to report at this time the marked improvement in the records which are sent to us. The statistical tables which I shall distribute this afternoon will show a relatively small number of cases which it has been necessary for us to classify under the caption "Unknown." It is our hope that when the necessity for careful tabulation is thoroughly realized by all nurses, even this small percentage can be eliminated.

The basis of my paper this afternoon will be the two tables which I am submitting herewith. The first is a record of the principal diseases and conditions nursed in twelve important cities in the United States. These cities are Baltimore, Boston, Brooklyn, Buffalo, Chicago, Cincinnati, Cleveland, Manhattan and Bronx Boroughs of New York City, Philadelphia, Providence, St. Louis and Washington. They represent a total of 31,482 cases, to whom 237,370 visits were made in the year 1914. All of these associations are well known, many of them of long standing, all of them under competent management. The fundamental principles of visiting nursing are recognized by all of these associations, and I think you will agree with me that the twelve cities mentioned are typical of the best nursing service known to us in this country. The results which are shown on this chart will therefore, to my mind, set up a standard for other organizations that will indicate the resultant of what is admittedly the best nursing practice.

It is impossible in this paper to go very far in analyzing the data herewith presented. I have had these figures before me repeatedly and have studied them for weeks, and yet each time I look at them I find some new fact, some new relation of disease to other conditions, some peculiar relation between the number of visits and the condition on discharge, which I had not noticed before. All that I shall attempt to do to-day is to analyze some of the more significant facts which are

brought out in this study. I cannot help but feel that it is a distinct contribution to the literature of visiting nursing, and it is my hope that the data submitted may be the basis of similar studies in the future.

AGE PERIOD

The value of visiting nurse service as an aid in life conservation will depend very much upon reaching those classes of the population who are still at the younger ages and who for this reason have a better expectancy of life. Our statistics show quite clearly that these groups are being reached. Of the total cases nursed, 34.7 per cent. were under twenty years of age and 72.2 per cent. under forty years of age. These averages seem to run fairly consistently for the twelve cities under review. The New York figures show, for example, that 45.5 per cent. of the patients nursed were under twenty years of age; Brooklyn, 46.3 per cent.; Chicago, 42.2 per cent.; Philadelphia, 26.1 per cent.; Baltimore, 33.8 per cent.; Boston, 35.1 per cent. Brooklyn shows the highest percentage and Philadelphia the least. It is probable that these percentages follow closely the age distribution in the population.

SEX DISTRIBUTION

The average for the twelve cities shows that 67.1 per cent. of the total cases are white females, 21.3 per cent. white males, 9.8 per cent. colored females and 1.8 per cent. colored males. The data obtained brings out an interesting fact and probably one well worthy of consideration. The sex distribution unquestionably does not follow the distribution in the population. It may be argued, since this is a selected class, sex distribution follows the distribution of policy-holders, but this likewise is not a fact. Two explanations might be offered for the apparently large number of white females nursed: (1.) That there is relatively more sickness, and (2.) that the advantages of visiting nurse work have not yet been fully brought home to the men insured in our Industrial department. Probably when the real cause is found, it will be seen that the excess of white females is due to the particular attention that has been given by visiting nurse associations in the care of maternity cases. There is food for thought, however, in the possibilities of educational work on the part of nursing associations to attempt to extend their activities not only to the female, but to the male population as well.

AVERAGE VISITS PER CASE

The record of the twelve cities investigated shows an average of 7.5 visits per case for all diseases and conditions. When analyzed along particular conditions we find that the average ranges from 2.3 visits per patient for "colds," coryza and rhinitis to 14 visits per patient for cancer and other malignant tumors. The practice of the nursing associations is very clearly brought out, when in connection with the average visits per case, we consider the average nursing days per case. It appears from the data that in cases of typhoid fever, to which an average of 13.4 visits per case were made, the duration of the nursing service was 17.9 days, or one visit, on the average, in 1.3 days. On the other hand, in pulmonary tuberculosis, where the average number of visits per case was 11.6, the duration of the nursing service was 87.5 days, or an average of one visit every 7.5 days. If it be remembered that these figures show the actual experience of twelve cities, it may probably be stated that the data herewith given may well be accepted as standards for the guidance of other organizations and associations.

CONDITION ON DISCHARGE

The statistical table which I have submitted shows that 10,505 out of 31,482 cases treated, or 34.1 per cent., were discharged as recovered; 43 per cent. were discharged as improved; 17.6 per cent. were discharged as unimproved, and 5.3 per cent. died. The value of these particular averages will be considered later in a discussion of the data submitted by some of the individual associations included in this study. I may say here that probably of all the data submitted on the records sent to us by the nursing associations, the condition on discharge has been the most difficult to determine accurately, and will probably give cause for discussion as to accuracy.

CASES NURSED WITH PHYSICIAN IN ATTENDANCE

You will note in Table 1 that only 76.2 per cent. of the total cases referred were cases which were nursed with a physician in attendance. In part, this is an arbitrary classification which we have been compelled to make by reason of certain limitations of our nursing service. In a service as extensive as ours, it has been impossible to eliminate entirely the reference of cases which require no nursing and of patients

TABLE I
METROPOLITAN LIFE INSURANCE COMPANY—VISITING NURSE SERVICE, 1914
Principal Diseases and Conditions Nursed in Twelve Important Cities* of the United States

DISEASE OR CONDITION	Number of Cases	Per Cent. of Total	AGE PERIOD					WHITE				COLORED				Number of Males	Per Cent. of Total	Average Visits per Case	Number of Nursing Days	Average Nursing Days per Case	CONNECTION ON DISCHARGE				TRANSFER TO																			
			Under 20	20-39	40-59	60 and Over	Male	Female	Male	Female	Male	Female	% Recovered	% Improved	% Unimproved						% Died	% to Self or Family	% to Institutions																					
TOTAL SERVICE—ALL DISEASES AND CONDITIONS.																							41337	100.0	15067	14772	7810	3688	9378	27543	703	3713	250096	100.0	6.0	667290	16.1	31.1	42.5	21.4	4.9	77.2	22.8	
Nursed With Physician in Attendance:																																												
Total—All Diseases and Conditions:																							31482	100.0	10930	11821	5970	2752	6693	21138	568	3063	237370	100.0	7.5	641853	20.4	34.1	43.0	17.6	5.3	79.2	20.8	
Typhoid Fever																							494	1.6	320	116	53	6	195	256	19	24	6779	2.9	13.4	8867	17.9	40.1	31.9	22.2	5.7	74.3	25.1	
Measles																							614	2.0	607	6	1		313	276	9	14	3367	1.5	5.5	6763	11.0	68.7	22.0	6.7	1.0	95.0	4.0	
Scarlet Fever																							366	1.2	354	12			162	199	5	8	2381	1.2	7.9	7818	21.4	60.8	22.7	13.0	3.6	96.2	3.8	
Whooping Cough																							302	1.0	295	5	2		121	169	4	8	1755	0.8	5.8	6522	21.3	22.4	60.7	12.9	4.1	85.2	14.8	
Diphtheria and Croup																							412	1.3	384	25	3		182	215	9	6	1910	0.8	4.6	4283	10.3	56.2	22.3	16.8	4.7	94.9	5.1	
GENERAL DISEASES (7412 cases, 23.5%)																							3672	2.8	176	268	313	109	117	556	20	174	4138	1.7	4.8	10557	12.2	39.6	53.3	5.7	1.0	98.9	10.2	
Pulmonary Tuberculosis																							1083	3.4	218	60	27	4	77	118	17	19	3006	1.3	13.0	12233	23.7	7.5	35.2	41.4	15.9	90.7	9.3	
Other Forms of Tuberculosis																							131	0.4	49	212	160	31	330	4	42	3679	2.6	14.0	14183	31.2	1.9	17.8	38.4	41.9	67.2	32.8		
Cancer and Other Malignant Tumors																							222	3.9	227	325	465	205	227	320	25	150	10394	4.3	8.4	30183	54.0	17.9	63.4	17.3	1.4	76.6	23.4	
Acute and Chronic Rheumatism																							1392	4.4	609	289	336	138	343	921	31	97	9771	4.1	7.0	23011	15.0	38.6	48.0	19.1	4.3	75.1	24.9	
Other General Diseases																							575	1.8	31	44	230	270	104	345	16	70	6759	2.8	11.8	21997	37.4	3.3	40.4	33.1	29.4	64.7	35.3	
DISEASES OF NERVOUS SYSTEM AND ORGANS OF SPECIAL SENSE (1830 cases, 5.8%)																							1830	5.5	1830	43	23	20	130	247	4	16	3023	1.3	6.5	8172	17.2	82.0	82.6	19.3	2	87.2	32.8	
Cerebral Hemorrhage, Apoplexy and Paralysis																							783	2.5	202	218	276	87	128	586	10	59	6176	2.6	7.9	19735	25.2	10.4	53.6	31.1	5.0	68.0	32.0	
Diseases of the Veins																							436	1.4	91	73	140	182	77	302	14	42	4435	1.9	10.2	13463	28.6	1.4	44.7	29.5	24.4	70.2	29.8	
Organic Diseases of the Heart																							459	1.3	2	73	233	101	25	386	2	16	4981	2.1	12.2	14797	36.2	10	56.4	23.0	7	61.9	38.1	
Diseases of the Circulatory System																							410	1.3	196	72	90	52	146	223	6	35	3455	1.5	8.4	9161	22.3	14.4	51.1	23.0	11.7	69.4	30.6	
DISEASES OF CIRCULATORY SYSTEM (1255 cases, 4.0%)																																												
"Colds," Coryza and Rhinitis																							385	1.2	260	61	50	14	127	225	9	24	901	4	2.3	2583	6.9	30.8	64.6	4	7	89.7	10.3	
Acute and Chronic Bronchitis																							1144	3.6	668	133	176	145	344	682	20	75	6154	2.6	5.4	14687	13.2	39.3	51.3	6.9	2	88.5	11.5	
Pneumonia—Lobar and Unilateral																							604	1.9	485	44	49	26	239	289	27	29	5719	2.4	9.5	7922	13.1	58.7	24.6	7.2	9.5	90.5	9.5	
Other Diseases of the Respiratory System																							1735	5.5	1174	214	236	116	147	828	64	96	13107	6.4	9.7	22233	12.8	44.6	38.7	10.7	9.0	87.2	12.8	
Pneumonia—Lobar and Unilateral																							464	1.8	174	115	183	64	149	325	10	82	3344	1.4	5.9	10631	18.8	26.2	55.0	17.3	1.3	77.9	22.1	
DISEASES OF DIGESTIVE SYSTEM (3513 cases, 11.2%)																																												
Tonsillitis																							1029	3.2	769	218	40	2	354	577	16	82	3380	1.4	5.9	10630	18.8	26.2	55.0	17.3	1.3	77.9	22.1	
Diseases of the Stomach																							638	2.0	269	138	185	66	130	385	19	95	3945	1.1	4.1	7231	11.4	25.5	60.9	12.3	1.2	81.4	18.4	
Diarrhea and Enteritis																							583	1.8	408	45	61	36	199	323	5	35	3647	1.5	6.6	1230	12.0	40.9	46.7	8.9	3.8	94.2	5.8	
Other Diseases of the Digestive System																							1263	4.1	631	424	327	111	262	901	19	111	9101	3.8	7.0	21933	17.0	27.4	48.7	19.1	4.8	76.2	23.8	
DISEASES OF GENITOURINARY SYSTEM (1710 cases, 5.4%)																																												
Non-venereal Diseases of Genitourinary System																							1710	5.4	160	733	576	212	1232	32	274	14069	6.3	8.7	30072	21.1	19.8	46.8	21.1	10.4	74.5	25.5		
Pregnancy, Childbirth and After Care																							3963	19.0	303	5333	326	0	5092	891	34182	14.4	5.7	80551	13.5	61.1	29.8	19.1				88.0	12.0	
Other Diseases and Conditions of the Female Sex																							1478	4.7	67	1308	100	1	100	13963	5.0	9.0	28787	18.1	40.6	40.3	8.5	1.3	85.1	14.9				
Peri State																							900	2.9	440	129	207	124	239	558	14	89	3266	2.7	12.4	12961	23.8	47.1	45.0	9.1	1.8	77.0	23.0	
Diseases of the Skin and Cellular Tissue																							507	1.6	332	81	66	28	201	272	8	28	6230	2.7	12.4	12961	23.8	47.1	45.0	9.1	1.8	77.0	23.0	
Burns																							401	4.5	408	278	402	291	441	879	41	78	12276	5.2	8.8	33182	33.1	25.9	59.0	15.0	1.0	76.0	24.0	
Traumatic Affections																							390	1.3	173	86	92	38	148	212	11	19	2709	1.1	6.9	6225	10.0	35.6	52.5	10.6	1.2	77.5	22.5	
Other External Causes																							641	2.0	189	131	189	143	429	12	57	4172	1.8	6.5	13691	21.4	14.3	51.5	30.6	3.5	67.4	32.6		
All Other Diseases and Conditions																																												
TOTAL "Nursed Without Physician," "Not Nursed" and "Non-policy-holders"																							6835	23.8	4137	2951	1831	936	2695	6400	135	630	12710	5.1	1.3	25707	2.6	19.0	40.8	37.1	3.1	69.2	30.8	
Nursed Without Physician in Attendance																							2244	5.4	1289	500	337	133	696	1456	30	90	3510	1.4	1.6	8515	3.8	14.9	47.4	37.5	2	80.0	20.0	
Non-policy-holders																							1233	3.0	353	441	185	97	311	744	25	97	1466	0.7	1.1	3494	2.8	13.4	31.1	47.8	7	61.9	38.1	
TOTAL "Nursed Without Physician," "Not Nursed" and "Non-policy-holders"																																												
Nursed Without Physician in Attendance																							447	10.5	1158	1549	898	378	1074	2962	42	287	5279	2.1	2.1	10684	2.5	18.0	40.1	38.9	3.9	60.1	39.9	
Not Nursed Without Physician in Attendance																							2331	4.9	997	456	414	167	601	1311	13	77	2275	0.4	1.1	3014	1.5	37.1	30.0	23.9	1.5	84.7	15.3	
Non-policy-holders																							1233	3.0	353	441	185	97	311	744	25	97	1466	0.7	1.1	3494	2.8	13.4	31.1	47.8	7	61.9	38.1	

*The twelve important cities comprise the following: Baltimore, Boston, Brooklyn, Buffalo, Chicago, Cincinnati, Cleveland, Manhattan and the Bronx, Philadelphia, Providence, St. Louis and Washington.
†Number of cases with unknown color, sex and age denoted by superior figures.

who have no physician, the latter under our rules not being entitled to more than the initial visit on the part of the nurse. Of the total cases not included under the above caption of "Cases Nursed with Physician in Attendance," 5.4 per cent. were nursed without a physician in attendance. This does not necessarily mean that our rule with respect to the physician has been violated. It means, as stated above, that an initial visit was paid. On the other hand, it does appear that 10.5 per cent. were not nursed, although a physician was in attendance. Our study of this particular group leads us to believe that many of these cases were brought to the attention of the nurse either too late to be of service or the illness was of such minor character as not to require nursing. Of the patients referred, 4.9 per cent. were not nursed for the reason that there was no physician. This requires no further explanation, as under the rules of the nursing service attention could not be given. Three per cent. of the cases were eventually found not to be policy-holders of the Company.

COMPARISONS BY CITIES

In order to bring out the value of these statistics, I am submitting to you Table 2, which shows the analysis, for important diseases and conditions, of six of the cities included under Table 1. Some of the data brought out in this analysis are exceedingly significant, and I am submitting it to you without comment or criticism. I am sure it is your desire, as well as mine, to obtain authentic and accurate information regarding the character of the work done by nursing associations generally, so that eventually it may be possible for us to set up definite standards. I have referred above to variations in certain cities in the age and sex distribution. Let us now analyze some of the other important facts connected with the associations in question.

If you will follow Table 2, you will see that the average number of visits per case for the twelve cities in question was 7.5 visits. The Henry Street Settlement of New York City shows a maximum of 8.5 visits per case; the Baltimore Association a minimum of 5.5 visits. Contrasted with this, New York shows a minimum of nursing days per case, namely, 12.6 days, and Baltimore a maximum of 36 days per case. The interpretation of these figures leads to the belief that the practice of the New York Association is to work as intensively as possible

with visits at frequent intervals. Baltimore, on the other hand, shows an interval of 6.5 days between visits. Brooklyn, Chicago and Philadelphia approximate each other very closely in the number of visits per case—Brooklyn having 6.9 visits and Chicago and Philadelphia 6.8 visits. On the other hand, both Brooklyn and Chicago show 20.1 and 20.2 days of nursing care per case, whereas Philadelphia shows only 15.2 days.

When we come to study the condition on discharge, we find an even more interesting and more illuminating set of figures. New York again stands at the top with a record of recovered cases of 56.8 per cent. Boston shows only 13.2 per cent. cases recovered. To any one knowing the method of work of these two organizations, it must be apparent that this marked difference in the number of patients who have recovered is not due to better or poorer work on the part of either organization, but evidently to the fact that the two organizations have set up different standards in determining what are "recovered," "improved" and "unimproved" cases. If the other four cities are taken into consideration in this particular classification, it will be seen that there is similarly a wide variation between Brooklyn, which shows 37.2 per cent. of cases recovered; Chicago, which shows 23.3 per cent.; Philadelphia, which shows 27.6 per cent., and Baltimore, which shows 25.7 per cent.

STANDARD NOMENCLATURE NECESSARY

I am inclined to believe from these figures that the time has come either to set up a new nomenclature to describe the condition on discharge, or else to define more clearly the terms at present used, such as "recovered," "improved" and "unimproved." It seems quite clear that in the use of these terms there is a wide difference of opinion. May I suggest that the Organization for Public Health Nursing give careful consideration to this matter, particularly as to the desirability of appointing a special committee on standards of nomenclature and classification.

When we consider the percentage of dead among cases nursed, we find a variation ranging from 5.9 per cent. in the case of New York to 4 per cent. in the case of Boston. This variation in part may be explained by different conditions in the respective cities and the possibility of a higher mortality in one city than in the other. On the other hand, it is interesting

to note that the city which has given the largest number of visits per case and shows the highest percentage of cases recovered, should have the highest lethal rate,* whereas the city with the smallest percentage of cases recovered should have the smallest lethal rate. These facts bring out matters for your consideration, as I suggested above. At the present moment, it is difficult to give satisfactory explanation for these differences by reason of the belief that different standards have been used in recording the facts.

The percentage of dead to the cases nursed brings up another thought. It is more than probable that each association has recorded the actual deaths occurring during the continuance of service. Certain cities to which I will advert later, show very clearly that many of the serious cases which are cared for by nursing associations are transferred to institutions, particularly to hospitals, and subsequently die there. Would it not be a desirable thing for the purposes of more accurate statistics if the nursing associations were to follow up these cases to determine whether the patients lived or died? It will be seen from the column "Transferred to Institutions" that a considerable portion of patients are thus treated. Baltimore has 38.2 per cent. of such patients to its credit; Boston only 16.9 per cent., and Philadelphia only 10.2 per cent. Here again the question of differences in practice is apparent. It is safe to say that all of the cities referred to have fairly ample hospital facilities for serious cases. The question which arises is an important one. Shall the nursing association attempt to give home care to patients who would probably be better off in hospitals, or not? It would appear from the figures which I have cited that at present there is no uniformity with respect to these cases, nor have any standards been set up which associations might follow with this very important class of patients.

VISITING NURSING IN COMMUNICABLE DISEASES

In Table 2 I have made still further analyses of these individual cities along the line of certain important diseases. The figures here, too, show that as yet there is a considerable divergence in the practice of the individual societies. For the four communicable diseases—measles, scarlet fever, whooping cough, diphtheria (and croup)—the visits per case vary from

*Number of deaths per one hundred cases treated.

TABLE 2

METROPOLITAN LIFE INSURANCE COMPANY—INDUSTRIAL DEPARTMENT
VISITING NURSE SERVICE, 1914

Principal Diseases and Conditions Nursed by Leading Associations

Cases Closed in 1914. All Diseases and Conditions (Part A); Principal Diseases and Conditions Separately Considered (Part B)

7.7 in the case of New York to 4.1 in the case of Boston. The nursing days per case vary from 16.9 in the case of Chicago to 8.4 in the case of Boston. The cost per case varies from \$4.40 in the case of New York to \$1.95 in the case of Boston. The percentage of cases recovered varies from 82.7 per cent. in the case of New York to 14.8 per cent. in the case of Boston; whereas the percentage of cases dead to cases nursed varies from 5 per cent. in the case of Baltimore to .8 per cent. in the case of Boston. Here again we have the rather interesting fact that apparently the society making the fewest number of visits per case at a minimum of cost is showing the smallest lethal rate. I do not wish you to understand that I believe that there is necessarily any relation between these two facts. They are probably due to the small number of cases under consideration. I cite this simply to indicate to you the exceedingly interesting data that are contained in these charts, in the hope that the same will be given careful study by each of you.

TUBERCULOSIS NURSING

The results of visiting nursing in pulmonary tuberculosis is brought out in Table 2. I cannot say that the outlook is a hopeful one. The visits per case range from 13 in the case of Philadelphia to 8.5 in the case of Brooklyn; the nursing days per case from 193.6 in the case of Baltimore to 18.1 days per case in New York. The cost per case varies from \$4.32 in Baltimore to \$6.23 per case in New York. The percentage of recovered cases in all cities is lamentably small. Brooklyn reports 1.1 per cent. as a maximum, and New York .5 per cent. Of the improved cases, Brooklyn reports 52.7 per cent. as a maximum; Philadelphia 11.6 per cent. as a minimum. Of the unimproved cases, Baltimore reports 73 per cent. as a maximum, with Brooklyn reporting 25.9 per cent. The percentage of dead to cases nursed indicates I think rather clearly that while visiting nurse work may be a distinct benefit to the tuberculous patient, it does not follow that the nursing itself has had any appreciable effect upon the lethal rate. Of the total tuberculosis cases nursed in Philadelphia, 58.7 per cent. died. In Baltimore, on the other hand, only 13.9 per cent. died. Here again we have the apparent anomaly of having the lowest death rate in the city showing a low ratio of visits per case. Possibly the low death rate in Baltimore is explainable by the fact that 72.4 per cent. of their patients

PART A

DISEASE OR CONDITION TREATED; NAME OF ASSOCIATION OR SERVICE	TOTAL CASES CLOSED		PER 1,000 MEANS IN FORCE		CASES NURSED WITH PHYSICIAN IN ATTENDANCE						NUMBER WITHOUT PHYSICIAN, NON-RECOVERED, ETC.
	Number	% of Total	White	Colored	Visits per Case	Nursing Days per Case	Cost per Case	% Recovered of Cases Nursed	% Died of Cases Nursed	% of Total Cases Closed	
All Diseases and Conditions	4137	10.6	12.2	76.2	7,539	24.1	2.73	99.34	1.52	20.38	23.8
Twelve Principal Associations and Services	2950	13.8	12.4	69.5	8,512	6.1	1.54	86.56	5.9	23.38	36.5
Henry Street Nurses' Settlement	4143	8.0	11.5	77.0	6,920	1.9	1.04	14.37	41.32	27.1	27.1
Brooklyn District Nursing Committee	2974	12.1	14.1	78.0	6,829	2.3	0.93	40.23	4.7	24.9	22.0
Visiting Nurse Association of Chicago	2674	14.7	17.4	82.6	6,515	2.3	0.93	40.23	6.7	10.25	22.6
Visiting Nurse Society of Philadelphia	2825	9.8	8.4	80.5	5,236	6.5	0.52	44.25	7.5	4.38	19.5
Visiting Nurse Association of Baltimore	2873	9.8	8.4	80.5	5,236	6.5	0.52	44.25	7.5	4.38	19.5
Visiting Nurse Association of Boston	3470	17.6	7.2	85.2	8,219	2.5	3.93	94.13	2.4	0.16	14.8

PART B

PRINCIPAL DISEASES AND CONDITIONS NURSED; NAME OF ASSOCIATION OR SERVICE	TOTAL CASES NURSED		PER 1,000 MEANS IN FORCE		CASES NURSED WITH PHYSICIAN IN ATTENDANCE						NUMBER WITHOUT PHYSICIAN, NON-RECOVERED, ETC.
	Number	% of Total	White	Colored	Visits per Case	Nursing Days per Case	Cost per Case	% Recovered of Cases Nursed	% Died of Cases Nursed	% of Total Cases Closed	
Four Communicable Diseases—(Measles, Scarlet Fever, Whooping Cough, Diphtheria and Croup)	1004	5.4	6.0	14.9	2.5	3.19	55.8	29.4	11.6	3.2	12.6
Twelve Principal Associations and Services	603	11.8	7.7	14.3	1.9	4.0	82.7	6.9	6.5	3.8	5.8
Henry Street Nurses' Settlement	275	11.0	6.7	16.4	2.4	4.02	66.4	26.5	5.0	1.1	11.5
Brooklyn District Nursing Committee	302	6.5	4.3	16.9	3.9	2.15	33.8	53.6	8.6	4.0	10.6
Visiting Nurse Association of Chicago	64	1.5	4.7	13.2	2.8	2.35	15.9	66.7	17.5	5.0	4.2
Visiting Nurse Society of Philadelphia	81	3.6	4.4	35.0	7.0	1.89	3.8	45.0	10.3	5.0	4.2
Visiting Nurse Association of Baltimore	123	4.2	4.1	8.4	2.0	1.95	14.8	57.4	27.1	1.8	16.4
Visiting Nurse Association of Boston	1083	3.4	11.6	87.5	7.5	6.17	14	23.0	44.5	11.1	59.5
Twelve Principal Associations and Services	103	3.3	10.9	18.1	1.7	6.23	5	28.5	47.7	23.3	53.9
Henry Street Nurses' Settlement	93	3.1	8.5	43.7	5.1	3.10	1	51.7	25.9	20.4	60.2
Brooklyn District Nursing Committee	316	3.6	9.0	33.8	3.8	4.50	6	13.9	53.9	31.5	69.0
Visiting Nurse Association of Chicago	140	3.2	13.0	49.1	3.8	6.50	7	11.6	29.0	58.7	29.1
Visiting Nurse Society of Philadelphia	127	3.5	9.6	193.0	4.2	4.32	8	12.3	73.0	13.9	77.4
Visiting Nurse Association of Baltimore	38	1.2	9.8	27	2.9	4.31	1	14.3	60.0	23.5	57.1
Visiting Nurse Association of Boston	1222	3.9	8.4	24.7	2.8	4.47	17	53.4	17.3	1.4	23.4
Twelve Principal Associations and Services	302	3.4	9.8	21.1	2.6	4.92	15.3	71.2	11.9	1.7	40.6
Henry Street Nurses' Settlement	122	4.1	2.8	24.0	3.2	3.45	6.8	70.1	20.2	2.7	17.5
Brooklyn District Nursing Committee	148	3.2	6.9	23.0	3.8	3.45	6.8	70.1	20.2	2.7	17.5
Visiting Nurse Association of Chicago	216	6.0	6.3	19.4	8.1	1.15	10.6	67.1	20.8	1.4	11.8
Visiting Nurse Society of Philadelphia	93	4.0	4.1	32.7	8.6	1.85	3.6	58.1	31.2	2.2	42.3
Visiting Nurse Association of Baltimore	142	4.8	10.4	27.8	2.7	4.94	11.3	73.2	14.8	1.7	17.6
Visiting Nurse Association of Boston	2339	7.4	8.9	12.9	1.4	4.73	48.4	32.9	9.8	9.1	11.8
Twelve Principal Associations and Services	743	12.0	11.3	10.8	1.0	6.46	75.6	4.7	8.9	10.3	10.6
Henry Street Nurses' Settlement	207	6.9	7.1	12.4	1.7	4.26	45.8	3.5	7.5	14.8	13.9
Brooklyn District Nursing Committee	298	6.4	7.3	10.5	2.1	3.65	26.9	53.2	12.8	7.1	16.0
Visiting Nurse Association of Chicago	318	13.7	8.8	20.4	3.1	2.90	17.3	62.6	14.6	6.6	23.5
Visiting Nurse Society of Philadelphia	119	5.1	6.6	14.1	3.1	2.97	50.8	27.1	12.7	9.3	16.8
Visiting Nurse Association of Baltimore	218	7.4	9.3	20.1	1.5	4.42	22.9	61.0	9.2	6.9	9.2
Visiting Nurse Association of Boston	594	10.0	5.7	13.5	2.4	3.83	51.0	29.8	19.1	12.0	13.0
Twelve Principal Associations and Services	585	14.0	7.0	6.3	1.3	2.86	75.0	10.7	14.4	1.3	13.9
Henry Street Nurses' Settlement	419	18.9	4.7	11.8	2.5	2.82	53.6	20.2	26.6	2.8	37.1
Brooklyn District Nursing Committee	753	17.7	5.9	18.6	3.2	2.85	47.9	39.6	12.5	2.5	24.8
Visiting Nurse Association of Chicago	1180	27.1	5.1	7.5	1.5	2.55	53.1	10.7	36.2	2.8	28.1
Visiting Nurse Society of Philadelphia	57	2.5	2.2	13.2	6.0	1.09	19.3	42.1	38.6	6.6	39.4
Visiting Nurse Association of Baltimore	568	10.2	6.5	20.0	3.1	3.99	5.8	83.5	10.7	1.6	23.5
Visiting Nurse Association of Boston	2336	7.4	9.1	22.0	2.4	4.84	32.2	54.5	11.8	1.6	23.5
Twelve Principal Associations and Services	247	5.9	9.5	13.4	1.0	4.53	20.4	7.1	11.3	2.3	39.8
Henry Street Nurses' Settlement	198	6.6	10.0	23.8	2.4	6.00	46.6	44.0	7.3	2.1	39.8
Brooklyn District Nursing Committee	399	8.0	8.8	11.0	2.7	2.40	90.1	66.9	13.3	1.6	13.4
Visiting Nurse Association of Chicago	311	2.7	7.1	1.8	2.7	2.40	18.2	66.9	13.3	1.6	13.4
Visiting Nurse Society of Philadelphia	281	11.3	6.4	26.5	4.1	2.89	31.3	40.9	18.1	1.8	40.0
Visiting Nurse Association of Baltimore	226	5.0	10.4	23.0	2.3	4.94	14.4	70.8	14.8	1.7	17.4
Visiting Nurse Association of Boston											

were transferred to institutions. The results shown in this column will explain in part why we have felt that tuberculosis nursing did not come within the purview of our work. It has been our impression all along that we would be doing most beneficial work for our policy-holders if our nursing service were limited as far as possible to acute diseases where the likelihood of recovery might be influenced by the nursing service given.

EXPERIENCE WITH PNEUMONIA NURSING

Of all the diseases that might be included in this last named category, we have felt pneumonia to be the most typical. The disease comes on somewhat suddenly, pursues a somewhat rapid course and the attention given to the patient during the illness may materially help in bringing about recovery. For these reasons the data given under "pneumonia" will be suggestive. The number of visits paid to patients in pneumonia cases has varied from 6.6 in Baltimore to 11.3 in New York. The number of nursing days per case has varied from 20.4 in Baltimore to 10.8 in New York. The percentage of recovered cases has ranged from 22.9 in Boston to 75.6 in New York, and yet anomalous as it may seem, New York shows a lethal rate of 10.8 and Boston a lethal rate of 6.9. New York has an average of nursing days per case of more than one visit per day. In this particular instance it is difficult to explain these figures by the fact of the transfer of patients to institutions. The New York figures show that 10.6 were transferred to institutions, whereas Boston shows only 9.2 per cent.

MATERNITY NURSING

We have always felt that the care of women in childbirth was a desirable feature of our nursing service. While we have always recognized that childbirth has no appreciable influence on our mortality, we have felt that the proper care of the mother and infant might mean a lessening of complications in later life. The care of the mother and baby has been well recognized by the nursing associations. The proportion of total cases for the twelve cities is 19 per cent. Of the cases nursed in Philadelphia 27.1 per cent. were normal maternity cases. Baltimore, on the other hand, shows only 2.5 per cent. Of particular interest to us is the number of visits per case. The average for the twelve cities is 5.7 visits. The

maximum of 6.5 visits is shown by Boston and the minimum of 2.2 visits by the city of Baltimore. These figures are particularly interesting to us by reason of the fact that on January 1, 1914, we limited the number of visits to be paid to maternity cases to 8. This limitation was modified on June 1, 1914. In our letter to nursing associations we suggested that it might not be necessary in normal cases for a visit to be made daily for eight days, as was claimed by a number of associations. The statistics bring out I think rather clearly the fact that our suggestion has borne fruit. The nursing days per case vary from 6.3 days in New York to 20 days in Boston. Brooklyn shows 11.8 days; Chicago, 18.6; Baltimore, 13.2; Philadelphia, 7.5 days. It is our impression from these figures that the nurses are giving necessary attention to maternity patients for the first few days and then instructing the mother and other members of the family in the care of the patient so that subsequent visits need be made only on alternate days or longer periods.

Finally, in Table 2, an analysis is given of external causes. This analysis is interesting only in that it shows the comparatively large proportion of cases of this kind which are being nursed. Of the total cases nursed in Baltimore 11.3 per cent. were from traumatisms. The lethal rate is highest for New York and Brooklyn. This possibly may be due to the peculiar conditions of congestion existing in these two cities, such as street traffic, etc. On the other hand, both of these cities show a large number of cases of this group referred to institutions. Baltimore, which has a lethal rate in this group of only .8 per cent., shows that 40 per cent. of these patients have been sent to institutions. This is probably due to the excellent hospital facilities in that city.

EXTENT OF THE SERVICE

May I call your attention for a moment to certain data given on the top of Table 2. You will see from this that in Manhattan and Bronx Boroughs of New York City we have nursed 13.8 white patients and 12.4 colored patients for every thousand policies which we have in force in these boroughs. Similarly, in Chicago, we have nursed 12.1 and 14.1 respectively; in Brooklyn, 8.6 and 11.5 respectively; in Philadelphia, 9.7 and 14.6 respectively; in Baltimore, 9.8 and 8.6 respectively, and in Boston 17.6 and 7.2 respectively.

In the paper which I read before this Association at a meeting two years ago, I called attention to the fact that the statistics of the sickness insurance associations in Germany have shown for many years that out of each one hundred members, 30 to 40 are receiving benefits by reason of incapacity due to illness or accident. If these figures are any criterion for the amount of sickness existing in the United States, then the percentage of cases of sickness among our policy-holders who are being nursed is lamentably small. In order to determine in a measure to what extent this might be true, we have made an intensive analysis of 2,968 deaths on which claims have been paid by the Company. Of these, 263, or 8.9 per cent., were nursed during their last illness, and 2,705, or 91.1 per cent., had no nursing.

A further study of these 2,705 cases shows that 1,499, or 55.5 per cent., could not readily have been nursed. Six hundred and ninety-seven, or 23.5 per cent., died in hospitals, sanatoria and other institutions. One hundred and eleven, or 3.7 per cent., were deaths by suicide, homicide and accidents. Fifty-eight cases, or 2 per cent., were sudden deaths due to cerebral hemorrhage, apoplexy, heart disease, etc.; 89, or 3 per cent., were acute cases of illness lasting three days or less. Two hundred and fifty, or 8.1 per cent., died in their homes but lived outside of the districts covered by the visiting nurse association. Ninety-three cases, or 3.1 per cent., did not want nursing service.

Of the remaining cases which could have been nursed, numbering 1,206, or 40.6 per cent., 49, or 1.7 per cent., were deaths due to infectious diseases of children. These are cases that we feel should have been nursed. The difficulty in the past has been the inability of the nursing associations in a great many cases to make provision for the care of infectious diseases. I feel, however, that the care of this particular group of diseases is one of the most important things for visiting nurse associations to consider. There has been a gratifying improvement in the last few years, and it is to be hoped in time that the visiting nurse associations can arrange to care for all classes of infectious disease, not only of children, but of adults as well. Of the remaining deaths, 308, or 10.4 per cent., were due to pulmonary tuberculosis; 100, or 3.4 per cent., were cancers; 463, or 15.6 per cent., were chronic diseases and conditions; 264, or 8.9 per cent., were policy-holders seventy years of age and over. As it has not been our policy to attempt to care for

chronic diseases, it is more than likely that the cases in these four groups were not given service because of our rule in the matter.

The figures I think bring out rather clearly the one thought which I had in mind to determine, namely, that we are only in the inception of our visiting nurse work, that there are still many policy-holders suffering from acute diseases who should have the benefits of nursing service, and that it is our duty as well as that of co-operating societies to try and develop ways and means so that all policy-holders who are in need of service may obtain it.

NEED FOR COMMUNITY SICKNESS STATISTICS

I cite the above largely to bring out the necessity of determining the amount of illness which exists in our respective communities. At the present moment there are no data whatever available. Records of benefit funds, sickness societies, etc., refer to a particular group and are not expressive of conditions existing in the population generally. Other studies which have been made in limited areas are, so far as I have been able to determine, unreliable.

It is with this thought in view that we are at the present moment contemplating a survey of sickness in the United States. The results which we have recently obtained through the use of our agents in making an unemployment survey for the United States Bureau of Labor Statistics leads us to believe that this machinery can be availed of to determine the percentage of sickness existing in the United States at a given day or week in the year. It is proposed to institute this survey during the coming fall, beginning with one typical city, and if results are found to be of sufficient value, we propose to extend the survey to practically all communities in which the Company has policy-holders. The schedule which is to be used for this will bring out significant facts of diagnosis so far as they are obtainable. It will attempt to ascertain the number of individuals in the family; the number bedridden at home; the number sick in hospitals; and the number ill at home but able to be up and about. The difficulty of obtaining accurate information with respect to the last named group is fully recognized. With this in mind, I believe that the result of such a survey will be of extreme value not only to the Organization for Public Health Nursing, but to all students of sickness and its social consequences.



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